Consumer Council System of Maine
A Voice for Consumers of Mental Health Services
www.maineccsm.org

Crisis RFP Comments

October 13, 2015

Overall principle

Please look back through time. Twenty years ago, there was very little money going to crisis services. In Portland, for example, the calls were taken by trained volunteers with one mental health staff added to support the volunteers. There was one state crisis worker per area to do mobile assessments, etc. There was a respite program with a duplex of two bedrooms: one double, one single.

Things were not so out of control with lack of resources. I am afraid we have built a very expensive system and I do not know if it ultimately has helped consumers of mental health services. We have also built a system of reliance for many people. As a person who has answered hotline calls and warm line calls, I know there is large amount of people that are repeat callers who are not in crisis. They would be better served with the warm line.

We are not saying we do not want a crisis system, we ask that this is thoughtfully planned out and we have concerns that the RFP has not accomplished this.

The RFP had an opportunity to write cutting edge recovery operated services. This is not what was published. We used old clinical models written in 1968.

We support the single line call center. The reason being is that we already have success with one single call center in the warm line. They take in excess of 30,000 calls a year from around the state. They transfer to crisis very little and take many crisis calls even though they are not advertised for this but they are capable and have a warm transfer to crisis when needed but those numbers are very low.

If the system is focused and started at the peer level, you have a much higher rate of resolving issues at the least restrictive setting possible and helps to support recovery. We can see what has

happened when we started at a higher level of service and where did our peers end up? Hospitals and Emergency Departments.

We had submitted a re-design for the entire system in both 2010 and 2013. The previous director of OAMHS embraced this model and was in the beginning stages of implementation when administrations changed and priorities changes.

The crisis system has also aided the message to go to the emergency department (ED) as well. They often did all or the many face to face assessments in the ED. We have taught consumers to use more expensive services that may not be the most helpful for people. Then we criticize people for going there.

What would we like to see?

A single call line that starts with the warm line and then is triaged if need to a community based support system. We applaud the Department for including peer specialists to the mobile team in the RFP but they are not equally paid and we see major problems recruiting full time professionals to fill these jobs at such a low rate. We need to value peer specialists for the life experience they bring to their positions. Last resorts are ED's and hospitalization. Higher use of crisis stabilization units.

We must also say that if we have any chance at making changes to the crisis system, like all services we find that DHHS lacks the capacity to enforce contracts. You can make a great bid, say you will do a lot of things and then if you don't have anyone looking over your program we lose greatly....

Submitted by Simonne Maline
Executive Director

Peer and Crisis Services

Wellness & Recovery Support System

Revisit to the CCSM 2010 Systems Re-design

Prepared for:
Office of Substance Abuse and Mental Health Services

By: **Consumer Council System of Maine**
A Voice for Consumers of Mental Health Services

www.MaineCCSM.org

Contents

Introduction

Systems change recommendations are a mandate of the CCSM mission. In that light, we are bringing forward some of the systems change and redesign work presented in 2010 as an opportunity that never came to fruition. We have used that work as a springboard to update this redesign presentation in the hope that it will have lasting impact to a much needed service system.

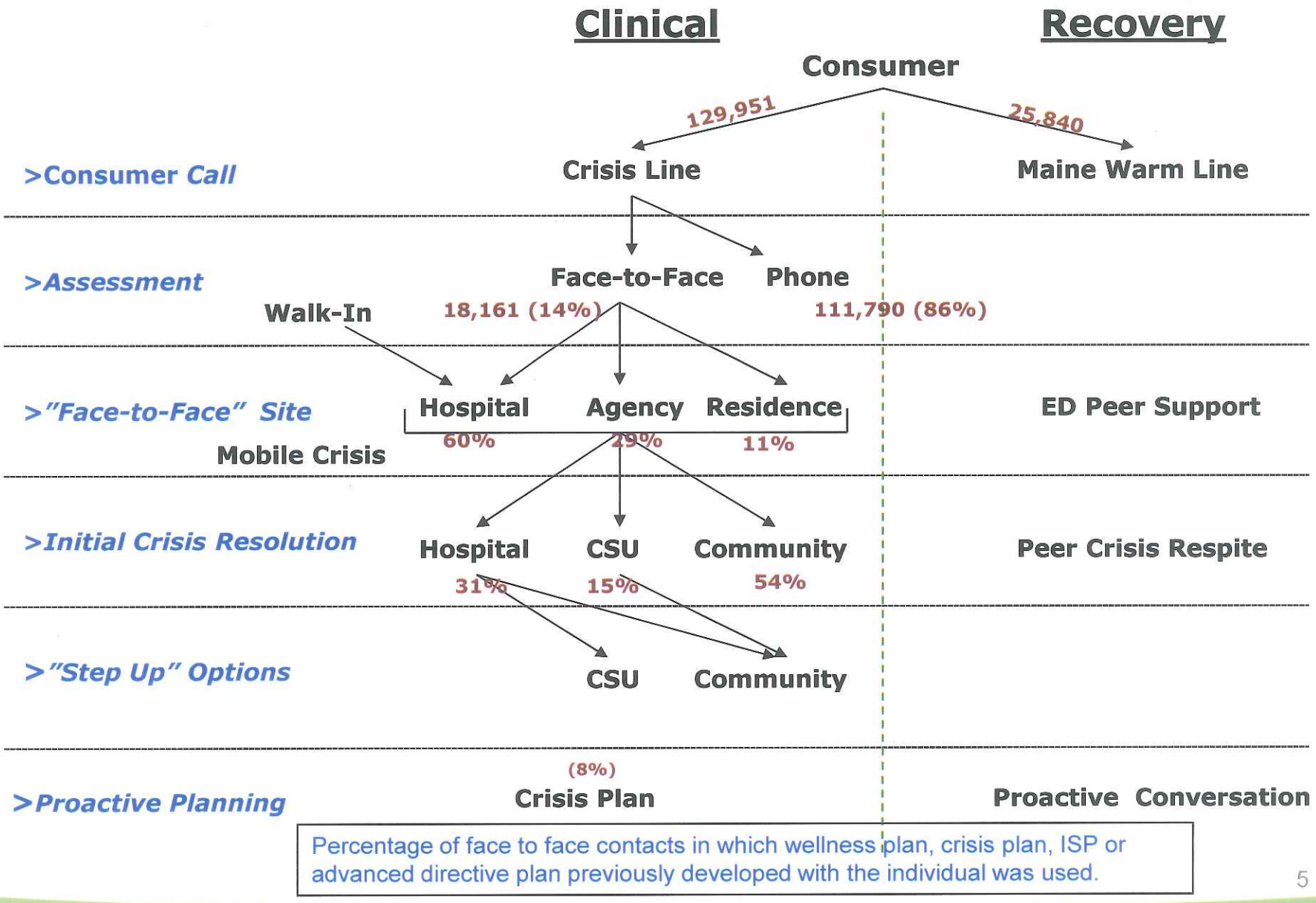
The following are points / philosophies / principles that we cannot lose sight of throughout this presentation (or document):

- Our focus has to be Strengths Based vs. Deficit Based
- We need to focus on the functions, not the title of current programs or positions
- We must define the Roles and Responsibilities of peers and community providers
- Focus on individuals needs, not what we currently offer for services
- Redefine Crisis-This shift in thinking should change how we look at re-defining the crisis system
- It is time for Redesign, not an update of what we have. It is much broader than that
- Peer Services need to be seen as a primary service to an adjunct or ancillary service

Merging Two Models: 2009

In 2009, the crisis system data looked like: see next slide…

Merging Two Models: 2009

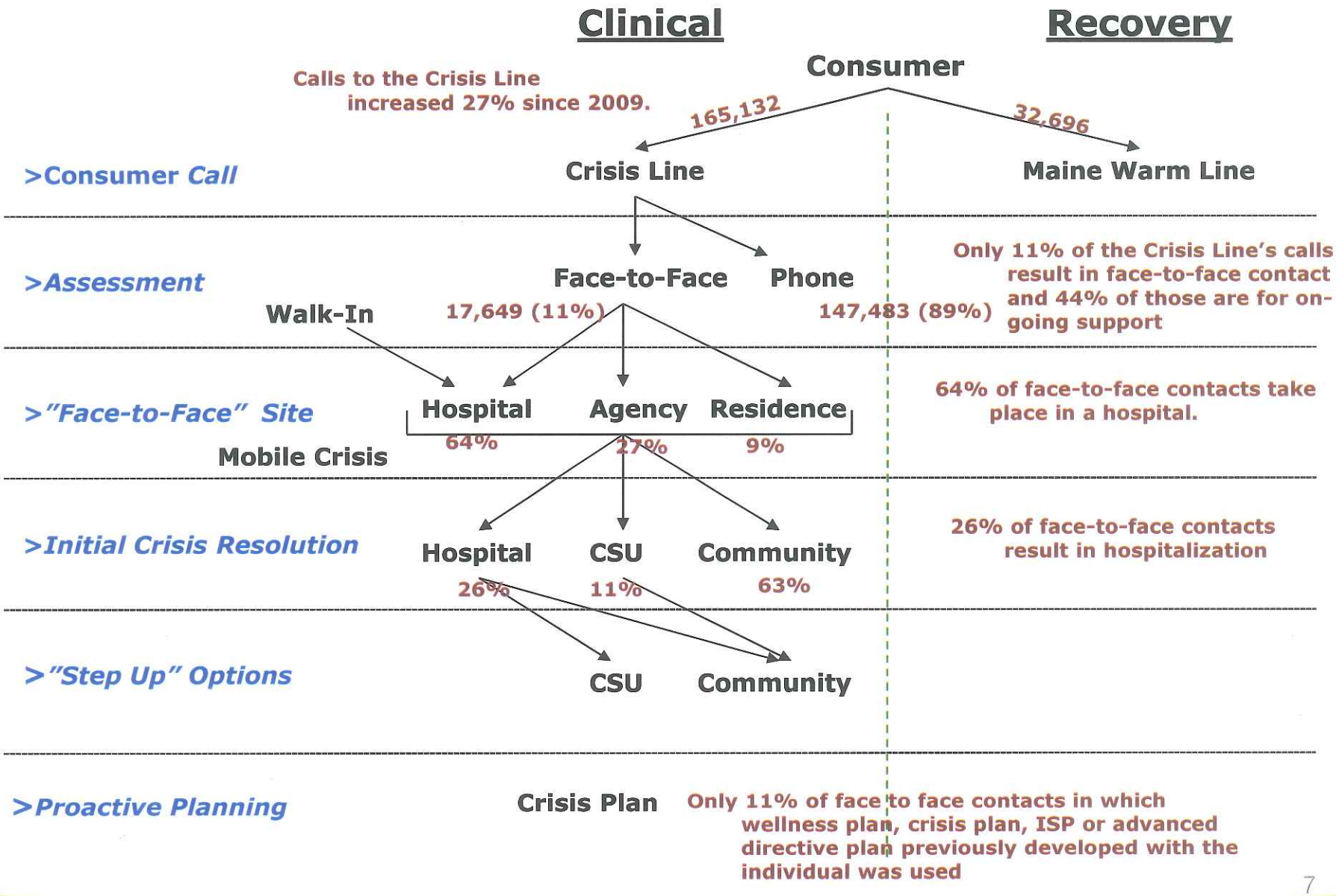


Percentage of face to face contacts in which wellness plan, crisis plan, ISP or advanced directive plan previously developed with the individual was used.

Maine Crisis System: 2013

Four years later, in 2013, unfortunately, the Maine crisis system data looks nearly the same. This brings forward the question "What HAS changed?" (See next slide…)

Maine Crisis System: 2013



Maine Crisis System: 2009 vs. 2013

Clinical

- Adult phone calls increased 22%.
- Liability and aversion to risk seem to be at an all time high.
- The clinical default is a higher level of service that often is not in the peers best interest or recovery focused.
- Face-to-Face assessments remained steady at 11%.
- In 2010, DHHS requested crisis providers to do their work very differently. The numbers do not support that this happened.
- Length of stay in Emergency Rooms has become a major crisis which only continues to get worse.
- Lack of psychiatric hospital beds.
- Loss of MaineCare brings people to the last alternative that is the

Recovery

- Phone calls increased to the Warm Line 26%.
- ED Program Trial with Mobile in Brunswick tried.
- Non-Contracted Peer Support added (TOA).
- Peer Coach with ED clients (Amistad).
- Integration of peer services into the service setting (Tri-County, for example).
- PATH navigators statewide.

The World Has Changed, Locally and Nationally

Clinical

- Health Care Collaboratives (HCC) were created with a wide variety of success.
- Multiple attempts to streamline systems for example: single presentation, ECR's have had limited success.
- Decreases in funding for MaineCare services has added additional strain to the Crisis System.
- Focus on Integration of Behavioral Health and Physical Health.

Recovery

- 8 Dimensions of Wellness (SAMSHA)
- New Peer Services in Maine
- Billable Peer Services explored
- National/International trends have given us new models of recovery and peer support
- Sharld Decision Making Pat Deegan mode;
- More opportunities to be trained as a Peer Support Specialist in Maine's IPS certification program.

Opportunities

- Looking at funding streams for best possible use of MaineCare and grant funds.
- Find the intersections that can give us the best opportunities for success. For the wellness and recovery of consumers in Maine

Wellness Recovery & Support System: Overview

Values and Ethics

A common set of Values and Ethics will be developed with input from stakeholders and driven by the consumer community. Anybody who works in the Wellness Recovery & Support System needs to have a thorough understanding of what Wellness and Recovery means and they need to adhere to those Values and Ethics . Program Decisions, Staff Actions and Quality Control will be guided by the Values and Ethics.

Training

Anybody who works in the Wellness Recovery & Support System will be trained in two models: Intentional Peer Support and Wellness Recovery Action Planning (WRAP).

Education

All interested individuals will have an opportunity to increase their understanding of Wellness and Recovery in the community and through the Wellness and Recovery Centers.

Support Line

A single Support Line would be staffed by Peers with lived experience and would be trained in Wellness and Recovery modalities. They will be able to answer calls regardless of where individuals fall on the Crisis spectrum and will be mindful of where people are at in that moment.

Calls requiring face-to-face intervention, assessment or support will be warm transferred to a Wellness & Recovery Center of their choice for additional support.

Wellness & Recovery Centers

Please see the diagram on the next page for an idea of how we envision what this program might look like. The program would be housed in a physical building where people could go to receive most of their peer support needs in ways that we have not seen before. The centers would have a significant variety of activities and resources available. This includes, but is not limited to: Respite, training, education and access to clinical services, if needed. It would also be a place where you could have one on one peer support and/or group conversations.

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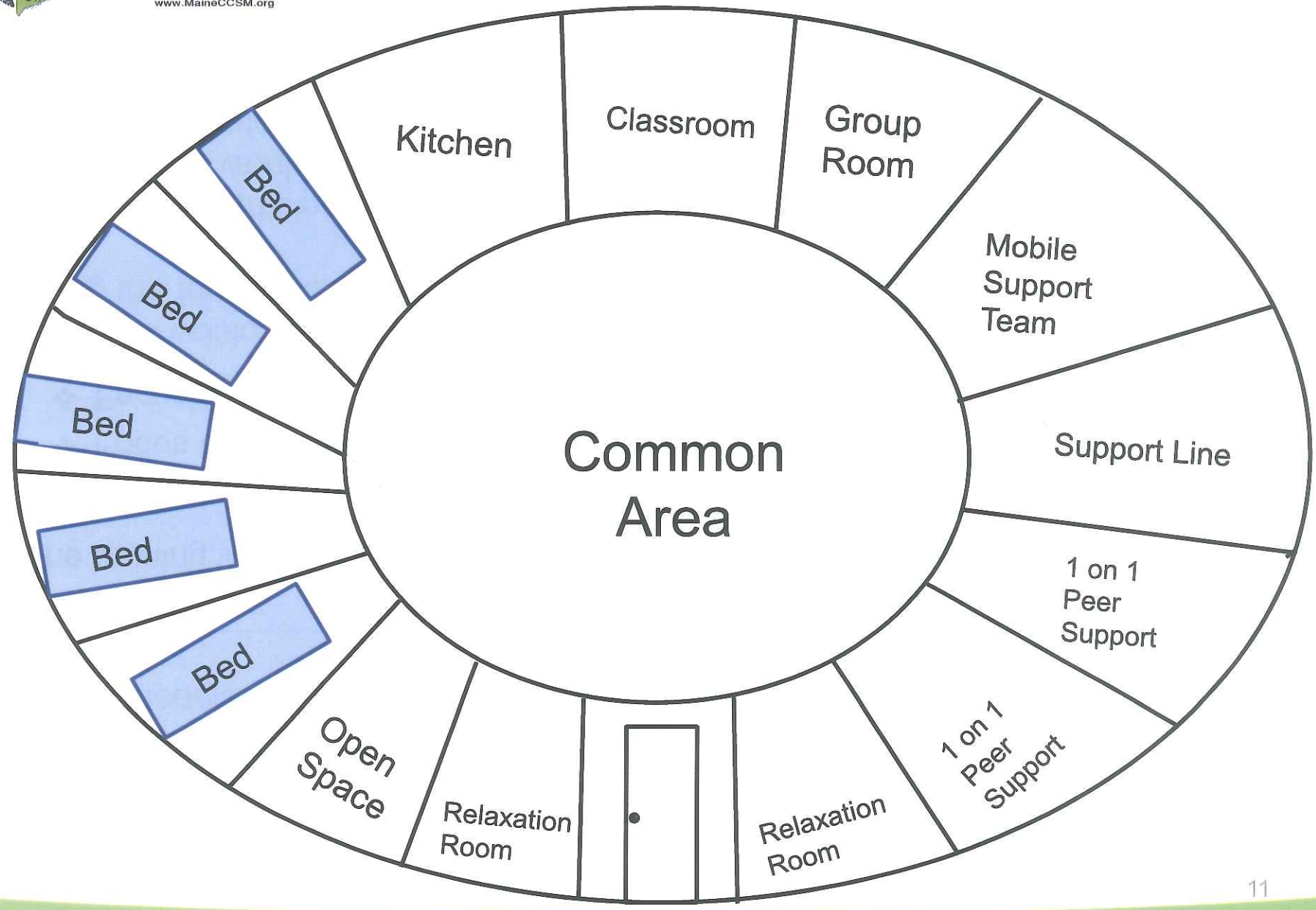

Training

Anybody who works in the Wellness Recovery & Support System will be trained in two models: Intentional Peer Support and Wellness Recovery Action Planning (WRAP).

The training will include the three principles of Intentional Peer Support:

- Focus on Learning rather than helping
- Focus on the relationship rather than on the individual
- Focusing on Hope and Possibilities rather than fear

Trainees would become well versed in how to use IPS and be able to model it using the four tasks: Connection, World View, Mutuality, Moving forward

All staff will participate in an approved Wellness Recovery Action Plan (WRAP) group. They would be required to take a minimum of a 16 hour, 2 day training that would preferably be the evidence based eight module group. Additionally, all staff will take the WRAP Facilitator training so they learn to model WRAP's Values & Ethics. This would allow them to facilitate groups and individuals in WRAP, including the Crisis Plan.

Education

All interested individuals will have an opportunity to increase their understanding of Wellness and Recovery in the community as well as through the Wellness and Recovery Centers.

Each Wellness and Recovery Center will provide the following groups:

- *WRAP (weekly)*
- *Peer Support Groups (twice weekly)*
- *Intentional Peer Support (quarterly)*

Additional Groups to be provided, but not limited to:

- *Whole Health Action Management (WHAM)*
- *Mental Health First Aid*
- *Recovery Workbook*
- *Non-Violent Communication*
- *Pathways to Recovery*

Support Line

A single Support Line will be staffed by Peers with lived experience who will be trained in Wellness and Recovery. They will answer calls regardless of where the individuals fall on the Crisis spectrum and will meet people from where they are in that moment.

Calls requiring face-to-face intervention, assessment or support will be warm transferred to a Wellness & Recovery Center of their choice for additional support.

- Clinical Support- We would want to partner with our clinical colleagues in work that is embedded with the values and ethics consistent with those listed previously.
- Decrease need for further intervention. This we believe will happen but, since we have not tested it, we have no data to back this up yet. Peer Specialists will also receive additional training in high risk situations.
- There will be structure for peer managerial oversight to back up peer specialists 24/7. Clinical consult would be available as needed.
- Cost Benefit will be in consolidating resources into one line. Also, this will result in less face to face contact and hospitalization if the focus is on prevention and education rather than on higher cost service.
- One Line – One agency – Multiple Locations to maximize peer support workforce.

Wellness & Recovery Centers

We envision a physical building that houses multiple supports for peers in one place.
We see this encompassing programs previously brought forward to SAMHS such as the living room project or diversion programs. This would bring about a much more unified flow and purpose.

Peers would be able to :

- Access support vs hospital emergency departments.
- No longer differentiate between peer respite and Crisis Stabilization Units. Everyone would be in the same place with individualized needs addressed.
- Utilize a continuum of wellness and recovery opportunities.
- See other peers who are working on their recovery as examples of people who are doing well.
- Access a place that would house multiple peer support opportunities.
- The staff would be peers, managed peers.
- Potential for billable services but clearly no one would be turned away due to ability to pay.
- Clinical support would be invited in at the peers discretion.

Wellness & Recovery Support System: Summary

- We are disappointed with the lack of movement in crisis services in the past 3 years since initial redesign and DHHS plans for change were introduced.
- The data supports this lack of movement in systems change.
- Peer Services have had very little opportunity to change or grow inside the resources of DHHS.
- We have a real opportunity for changes in the system going forward if people are willing to look beyond their own stake in their programs for the betterment of the consumers in Maine who should be the drivers of the service system.
- We look forward to engaging in meaningful reform of the current system as we look to again moving forward a recovery oriented system of care.

Maine Department of Health and Human Service

Integrated Monthly Crisis Report (Page 1 of 2)

State Wide Agency Report - Initial

Substance Abuse and Mental Health Services
An Office of the Department of Health and Human Services

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

07-01-2013 To 06-30-2014

I. Consumer Demographics (Unduplicated Counts - All Face To Face)

Gender	Children	Males	2,491	Females	2,954				
	Adults	Males	10,090	Females	11,188				
Age Range	Children	< 5	66	5 - 9	700	10 - 14	2,260	15-17	2,419
	Adults	18 - 21	2,187	22 - 35	6,689	36 - 60	10,170	>60	2232
Payment Source	Children	MaineCare	3,825	Private Ins.	1,363	Uninsured	249	Medicare	8
	Adults	MaineCare	11,178	Private Ins.	3,210	Uninsured	5,815	Medicare	1,075

II. Summery Of All Crisis Contacts

	Children	Adults
a. Total number of telephone contacts	27,633	145,488
b. Total number of all Initial face-to-face contacts	4,655	16,249
c. Number in II.b. who are children/youth with Mental Retardation/Autism/Pervasive Dev. Disorder	419	
d. Number of face-to-face contacts that are ongoing support for crisis resolution/stabilization	770	4,924

III. Initial Crisis Contact Infomation

	Children		Adults	
a. Total number of Initial face-to-face contacts in which a wellness plan, crisis plan, ISP or advanced directive plan previously developed with the individual was used	483	10.4%	429	2.6%
b. Number of Initial face to face contacts who have a Community Support Worker (CI,CRS,ICM, ACT,TCM)	1,880	40.4%	4,849	29.8%
c. Number of Initial face-to-face contacts who have a Comm. Support Worker that was notified of crisis	1,610	85.6%	4,125	85.1%
d. SUM time in minutes for all Initial face to face contacts in II.b. from determination of need for face-to-face contact or when individual was ready and able to be seen to Initial face-to-face contact			484,239	30
e. Number of Initial face-to-face contacts in Emergency Department with final disp. within 8 hours			8,513	52.4%
f. Number of Initial face-to-face contacts not in Emergency Department with final disp. within 8 hours			6,240	38.4%

CHILDREN ONLY Time from determination of need for face to face contact or when individual was ready and able to be seen to initial face to face contact.

Less Than 1 Hour.	3971	1 to 2 Hours	557	2 to 4 Hours	102	More Than 4 Hours	25			
Percent	85.3%	Percent	12.0%	Percent	2.2%	Percent	0.5%			

CHILDREN ONLY Time between completion of initial face to face crisis assessment contact and final disposition/resolution of crisis

Less Than 3 Hours	1942	3 to 6 Hours	2126	6 to 8 Hours	168	8 to 14 Hours	151	> 14	265	
Percent	41.7%	Percent	45.7%	Percent	3.6%	Percent	3.2%	Percen	5.7%	

IV. Site Of Initial Face To Face Contacts

	Children		Adults	
a. Primary Care Residence (Home)	657	14.1%	1,487	9.2%
b. Family/Relative/Other Residence	154	3.3%	117	0.7%
c. Other Community Setting (Work, School, Police Dept, Public Place)	371	8.0%	461	2.8%
d. SNF, Nursing Home, Boarding Home	1	0.0%	58	0.4%
e. Residential Program (Congregate Community Residence, Apartment Program)	34	0.7%	242	1.5%
f. Homeless Shelter	9	0.2%	134	0.8%
g. Provider Office	130	2.8%	608	3.7%
h. Crisis Office	663	14.2%	2,563	15.8%
i. Emergency Department	2,552	54.8%	9,718	59.8%
j. Other Hospital Location	71	1.5%	570	3.5%
k. Incarcerated (Local Jail, State Prison, Juvenile Correction Facility)	13	0.3%	291	1.8%
Totals:	4,655	100%	16,249	100%

V. Crisis Resolution - Initial Encounters (Mutually Exclusive Exhaustive)

	Children		Adults	
a. Crisis stabilization with no referral for mental health/substance abuse follow-up	140	3.0%	907	5.6%
b. Crisis stabilization with referral to new provider for mental health/substance abuse follow up	990	21.3%	3,243	20.0%
c. Crisis stabilization with referral back to current provider for mental health/substane abuse follow up	1,681	36.1%	5,269	32.4%
d. Admission to Crisis Stabilization Unit	702	15.1%	2,036	12.5%
e. Inpatient Hospitalization Medical	24	0.5%	407	2.5%
f. Voluntary Psychiatric Hospitalization	1,102	23.7%	3,360	20.7%
g. Involuntary Psychiatric Hospitalization	15	0.3%	677	4.2%
h. Admission to Detox Unit	1	0.0%	350	2.2%
Totals:	4,655	100%	16,249	100%

Maine Department of Health and Human Services

Integrated Monthly Crisis Report (Page 2 of 2)

State Wide Agency Report - Initial

07-01-2013 To 06-30-2014

VI. Initial Encounters - Crisis Assessment Criteria	
a. Depression	3,447
b. Anxiety	2,102
c. Behavioral Issues youth	1,873
d. Suicidal Ideation or Act	5,941
e. Homicidal Ideation or Act	265
f. Self-Injury/Assaultive Behavior	610
g. Medical Attention Needed	308
h. Grief and Loss	131
i. Substance Abuse	1,643
j. Domestic Abuse	78
k. Acute Stress	1,033
l. Deliberate Self harm	91
m. No Medical - Based Change in Mental Status	48
n. Sexual Assault	15
o. Mental Health Symptom Decompensating	1,812
p. Psychosis	1,507
Total:	**20,904**